Complete Summary

GUIDELINE TITLE

Evidence-based clinical practice guideline. Nursing management of the second stage of labor.

BIBLIOGRAPHIC SOURCE(S)

Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). Nursing management of the second stage of labor. Evidence-based clinical practice guideline. Washington (DC): Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN); 2000 Jan. 29 p. [55 references]

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Second stage of labor in pregnancy

GUIDELINE CATEGORY

Evaluation
Management

CLINICAL SPECIALTY

Family Practice
Nursing
Obstetrics and Gynecology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Nurses

GUIDELINE OBJECTIVE(S)

- To provide clinical practice recommendations for management of the second stage of labor based on a comprehensive review of the best available scientific evidence
- To provide perinatal registered nurses, certified nurse midwives (CNMs) and Canadian midwives with information necessary to optimize perinatal outcomes by the following means:
    - Empowering, preparing and supporting the woman and her family during the second stage of labor
    - Promoting alternative and nondirected pushing techniques based on current evidence
    - Recognizing, responding to and evaluating the physiologic and psychologic processes occurring during the second stage of labor

TARGET POPULATION

Women during the second stage of labor for whom a vaginal birth is a planned, anticipated event and who have no identified contraindications for pushing or vaginal birth

INTERVENTIONS AND PRACTICES CONSIDERED

Management of the Second Stage of Labor

1. Educational preparation of the woman for the second stage of labor, including providing information on the following:
    - Realistic estimation of the duration of second stage of labor
    - Variety of sensations to be experienced
    - Delayed and nondirected pushing techniques
    - Positions woman might assume (e.g., potential benefits of upright position)
    - Benefits of having support persons present
2. Supportive care: physical, emotional, instructional and advocacy, including the following
    - Encouraging ambulation and frequent position changes
    - Promoting physical comfort (e.g., cool or warm compresses, changing linens, massage, touch, offering fluids)
    - Providing emotional support
    - Providing information and instruction throughout labor to reduce stress
    - Facilitating collaboration on behalf of woman and her partner regarding care decisions/preferences.
3. Positioning (e.g., use of upright or lateral position, changing positions)
4. Facilitating delayed and nondirected pushing techniques, including:
    - Assessing woman's knowledge and expectations for pushing, presence of Ferguson' s reflex and readiness to push, fetal presentation and positioning

- Encouraging open glottis pushing
- Discouraging breath holding for 10 seconds with each contraction
- Providing birthing aids, such as birthing balls, squat bars, birthing stools and cushions

5. Evaluation of physiologic processes, including:
    - Evaluating effects of pushing efforts and positioning on fetal descent
    - Support and facilitation of the woman's pushing efforts

Note: The use of fundal pressure is considered but not recommended.

MAJOR OUTCOMES CONSIDERED

- Women's satisfaction with labor and birth (primary outcome)
- Other labor and birth outcomes (rates of episiotomies, duration of labor, pain intensity; rates of perineal trauma, neonatal morbidity)

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The original search was conducted using both MEDLINE and the Cumulative Index of Nursing and Allied Health Literature (CINAHL) databases. The search was limited to articles in English published between 1990 and 1999, in which any one of the terms labor, obstetrical nursing, labor complications or delivery were present. In addition, these terms were combined with the following terms: social support, nurse-patient relationships and helping behavior. Additional search terms included posture, bearing down, Valsalva and pushing. The stipulation for the search parameters was that the terms be present in the body (text) of the article. Reports not addressing terms specifically related to the second stage of labor were eliminated.

Additional articles were retrieved based on personal knowledge of critical works and a review of references included in the articles reviewed.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Quality of Evidence

I: Evidence obtained from at least one properly designed randomized controlled trial.

II-1: Evidence obtained from well-designed controlled trials without randomization.

II-2: Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group.

II-3: Evidence from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of the introduction of penicillin treatment in the 1940s) could also be regarded as this type of evidence.

III: Opinions of respected authorities, based on clinical experience, descriptive studies or reports of expert committees.

Quality of Evidence Rating for Qualitative Studies

The quality of evidence rating is based on the total scores for each of five categories:

1. descriptive vividness
2. methodological congruence
3. analytical preciseness
4. theoretical connectedness
5. heuristic relevance

QI: Total score of 22.5-30: 75-100% of total criteria met

QII: Total score of 15-22.4: 50-74% of total criteria met

QIII: Total score of 15 or less: 54% or less of total criteria met

The categories are described in the Criteria for Quality Rating in Appendix C of the original guideline document.

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) template for guideline development is based on the framework delineated in the American Nurses Association (ANA) Manual to Develop Guidelines (Marek KD, American Nurses Association Committee on Nursing Practices, Standards and Guidelines. Washington [DC]: American Nurses Publishing, American Nurses

Foundation, American Nurses Association, 1995). The American Nurses Association Manual to Develop Guidelines models its process on that of the Agency for Healthcare Research Quality (AHRQ), formerly the Agency for Health Care Policy and Research (AHCPR).

Team members participated throughout 1999 and 2000 in teleconferences; literature review, evaluation and scoring of research articles; ongoing progress reports and process evaluation; and creation of the Evidence-Based Clinical Practice Guideline. Group consensus was used to delimit the multidisciplinary literature reviewed and accepted for use in this Guideline.

A system and tool for scoring the literature was developed based on the method for literature analysis presented in the American Nurses Association Manual to Develop Guidelines (Marek, 1995). Using this framework, each study reviewed by the Guideline team was evaluated in the following eight categories:

1. Problem or question studied
2. Sampling
3. Measurement
4. Internal validity
5. External validity
6. Construct validity
7. Statistical conclusion validity
8. Justification for conclusions

A description of the above criteria and a sample scoring tool are included in Appendix A of the original guideline document. As the Evidence-Based Clinical Practice Guideline was further developed, the quality of the evidence supporting practice recommendations was determined by team consensus using the U.S. Preventive Services Task Force (1996) Guide to Clinical Preventive Services quality of evidence rating scale.

Because several research reports were qualitative in nature, the team determined different criteria were required to evaluate the quality of such evidence. Consequently, the team generated a scoring tool based on evaluative criteria of qualitative research discussed by Burns and Grove (Understanding nursing research [2nd ed.]. Philadelphia: WB Saunders Co., 1999). Criteria for rating included the following (Burns N. Standards for qualitative research. Nurs Sci Quart 1989;2:44-52):

1. Descriptive vividness
2. Methodological congruence
3. Analytical preciseness
4. Theoretical connectedness
5. Heuristic relevance

A detailed description of these criteria and a sample scoring tool are included in Appendix C of the original guideline document.

Each clinical practice recommendation presented in the Guideline is supported by a referenced rationale using American Psychological Association (APA) format. The column headed Evidence Rating includes the quality of evidence ratings for each

reference cited under the column headed Referenced Rationale. Full citations for all references are given in the reference list of the original guideline document.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Clinical Validation-Pilot Testing
Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

- This guideline was peer reviewed by a panel of Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) expert members.
- Clinical validation and pilot testing was conducted via AWHONNs Research Based Practice Project; the guideline was implemented by nurses in selected clinical sites prior to publication.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Quality of Evidence Ratings (I-III and QI-QIII) are defined at the end of the "Major Recommendations" field.

Preparation of the Woman

Assessment

1. Assess all pregnant women prenatally for their understanding of the sensations, expectations and knowledge deficit about the second stage of labor. This assessment should be repeated at the onset of labor (Brown & Lumley, 1994: Evidence Rating: III) (McKay et al., 1990; Mackey, 1998: Evidence Rating: QI).

2. Assess the pregnant woman's available support system for the second stage of labor. This should be started during the prenatal period and repeated at the onset of labor (Kennel et al., 1991; Scott et al., 1999: Evidence Rating: I) (Khazoyan & Anderson, 1994; Mackey, 1998: Evidence Rating: QI).

Intervention

1. Present realistic guidelines for pregnant women regarding the second stage of labor through childbirth curriculum, classes and health care provider interactions. This should be done during the prenatal period and again at the onset of labor. The information should include but not be limited to the following (Mackey, 1998; McKay et al., 1990; Callister, 1993: Evidence Rating: QI):
    a. Duration of the second stage of labor may exceed the woman's expectations (McKay et al., 1990: Evidence Rating: QI).
    b. Sensations of the second stage of labor may include relief, increased discomfort, burning, stretching, involuntary pushing, increased effort and/or a diminished or absent urge to push (Mackey, 1998; McKay et al., 1990: Evidence Rating: QI).
    c. Pushing techniques may vary. Spontaneous pushing efforts include an open or closed glottis (Parnell et al., 1993: Evidence Rating: II) (Woolley & Roberts, 1995: Evidence Rating: II-1).
    d. A variety of upright positions may be used, such as kneeling, squatting, sitting and/or standing (Gardosi et al., 1989: Evidence Rating: I).
2. Encourage pregnant women to have support people present for their labor and birth and educate them regarding the following (Kennel et al., 1991: Evidence Rating: I):
    a. Benefits of having support during labor including the labor nurse, family members and significant others
    b. Availability of alternative sources of support, such as doulas.

    (Scott et al., 1999; Hodnett & Osborn, 1989: Evidence Rating: I) (Mackey, 1998: Evidence Rating: QI)

3. Encourage labor support respecting individual desires and cultural influences (Khazoyan & Anderson, 1994: Evidence Rating: QI).

Expected Outcomes

1. Pregnant women will receive consistent education, information and preparation from childbirth educators, prenatal care providers and intrapartum providers regarding the duration, expectations and sensations of the second stage of labor (Mackey, 1998; McKay et al., 1990: Evidence Rating: QI).
2. Women will have a supportive person present during their second stage of labor (Kennel et al., 1991; Scott et al., 1999; Hodnett & Osborn, 1989: Evidence Rating: I) (Khazoyan & Anderson, 1994; Mackey, 1998: Evidence Rating: QI).

Supportive Care

Assessment

1. Assess the woman throughout the prenatal period to evaluate the need for physical, emotional, instructional, psychosocial and supportive care. On admission to the labor and delivery unit, assess the woman's expectations and concerns regarding clinical management, use of pain medication and presence of loved ones and support persons (Bryanton et al., 1993; Roberts & Woolley, 1996: Evidence Rating: III) (Callister, 1993: Evidence Rating: QI) (Simkin, 1991: Evidence Rating: QII).
2. Evaluate labor coach's knowledge of physical, emotional and psychosocial support needed during labor and augment as needed to meet individual needs (Gagnon et al., 1997: Evidence Rating: I) (Nichols, 1993: Evidence Rating: QI).

Intervention

Physical Comfort

1. Promote well-being and relief of pain by encouraging ambulation, facilitating position changes, applying cool or warm compresses, changing linens, underpads and gowns, offering fluids as ordered and providing massage and touch (Gagnon & Waghorn, 1996: Evidence Rating: III) (Callister, 1993: Evidence Rating: QI).
2. Validate and explain the physical sensations experienced by the woman during the second stage of labor (McKay et al., 1990: Evidence Rating: QI).
3. Explain the need for vaginal examination and the pressure and/or pain sensations anticipated. Negotiate when exams will be performed whenever possible. Perform vaginal examinations only as needed, share findings with the woman and her partner and acknowledge and apologize for the discomfort caused during these procedures (Bergstrom et al., 1992; Mackey, 1998: Evidence Rating: QI).

Emotional Support

1. Provide reassurance, empathy and encouragement to the woman by methods such as the following:
    a. Acknowledgment of the stress and work of labor
    b. Praise
    c. Acknowledgement of unpleasant sensations
    d. Presence with the woman
    e. Encouragement to express fears and concerns
    f. Engagement in conversation

    (Mackey, 1998: Evidence Rating: I) (Roberts & Woolley, 1996: Evidence Rating: III)

2. Accept the woman's behavior, vocalizations or spontaneous grunts as helpful/productive (Bryanton et al., 1993; McKay et al., 1990; Roberts & Woolley, 1996: Evidence Rating: III).
3. Assist the labor coach by encouraging supportive behaviors and providing relief/break periods and access to nourishment during the second stage of

labor (Kennell et al., 1991: Evidence Rating: I) (Mackey, 1998: Evidence Rating: III) (Nichols, 1993: Evidence Rating: QI).

Instructional Support

1. Reduce the stress caused by lack of knowledge or fear of the unknown. Examples include the following:
    a. Explanation of present and anticipated events, procedures and care provider findings
    b. Coaching
    c. Advising
    d. Empowering the woman and significant others to ask questions and seek clarification

    (Brown & Lumley, 1994; Bryanton et al., 1993: Evidence Rating: III) (Callister, 1993: Evidence Rating: QI)

2. Identify information needed by the woman to push (McKay et al., 1990; Mackey, 1998: Evidence Rating: QI).
3. Answer questions honestly and truthfully in language that is easily understood by laypersons (Gagnon & Waghorn, 1996: Evidence Rating: II-3) (Mackey, 1998: Evidence Rating: QI).

Advocacy

1. Facilitate collaboration on behalf of the woman to support care decisions and preferences whenever possible (Brown & Lumley, 1994: Evidence Rating: III) (Mackey, 1998: Evidence Rating: QI) (Simkin, 1991: Evidence Rating: QII).
2. Except as clinically necessary, limit the people present at birth to those requested/designated by the woman in labor (Brown & Lumley, 1994: Evidence Rating: III) (Simkin, 1991: Evidence Rating: QII).
3. Assist the labor coach by encouraging supportive behaviors, providing instruction to promote maternal-infant safety and well being, providing relief/break periods, access to nourishment and directing when to change apparel appropriate to the birth setting (Kennell et al., 1991: Evidence Rating: I) (Mackey, 1998; Nichols, 1993: Evidence Rating: QI).

Expected Outcomes

1. The woman will express satisfaction with her experience during the second stage of labor (Roberts & Woolley, 1996: Evidence Rating: III) (Callister, 1993: Evidence Rating: QI).
2. The support person will provide appropriate assistance during labor and will also feel supported (Nichols, 1993: Evidence Rating: QI).

Positioning

Assessment

1. Assess the woman's knowledge regarding positioning during the second stage of labor (McKay et al., 1990: Evidence Rating: QI).

2. Assess the woman's ability to maintain effective alternative/upright positions during the second stage of labor (Gardosi et al., 1989: Evidence Rating: I).
3. Assess fetal presentation, position, station and descent (Fenwick & Simkin, 1987; Roberts & Woolley, 1996: Evidence Rating: III) (Bergstrom et al., 1992: Evidence Rating: QI).

Intervention

1. Continue to provide information to the laboring woman and her partner regarding positioning throughout the second stage of labor (Brown & Lumley, 1994: Evidence Rating: III) (Callister, 1993: Evidence Rating: QI).
2. Assist the woman in using an upright position during the second stage of labor whenever possible. Maintaining an upright position during labor may have the following effects:
    a. Increase the pelvic diameter (Fenwick & Simkin, 1987: Evidence Rating: III).
    b. Decrease the duration of the second stage of labor (Liu, 1989; Allahbadia & Vaidya, 1993: Evidence Rating: I) (Golay et al., 1993: Evidence Rating: II-2).
    c. Minimize the intensity of pain (de Jong et al., 1997; Waldenstrom & Gottvall, 1991: Evidence Rating: I).
    d. Decrease the incidence of perineal trauma (de Jong et al., 1997; Gardosi et al., 1989: Evidence Rating: I) (Golay et al., 1993: Evidence Rating: II-2).
    e. Increase satisfaction with the birthing experience (Waldenstrom & Gottvall, 1991: Evidence Rating: I).
3. Encourage use of upright positioning aids to support the woman and the pelvis, such as birthing balls, cushions, squat bars and birthing stools. During contractions, the nurse or woman's partner may assist in providing added support (Gareberg et al., 1994: Evidence Rating: III) (Allahbadia & Vaidya, 1993 Evidence Rating: I).
4. Whenever possible, facilitate lateral positioning if the woman is unable to maintain the upright position for the second stage of labor (Albers et al., 1996: Evidence Rating: II-2) (Roberts & Woolley, 1996: Evidence Rating: III).
5. Assist the woman in changing positions frequently, especially if there is lack of descent of the fetal head (Liu, 1989: Evidence Rating: I) (Fenwick & Simkin, 1987: Evidence Rating III).

Expected Outcome

1. Women will use positions of their choice to promote comfort and facilitate fetal descent during the second stage of labor if no maternal or fetal contraindications exist (Brown & Lumley, 1994: Evidence Rating: II-3) (Simkin, 1991: Evidence Rating: QII).

Delayed and Nondirected Pushing Techniques

Assessment

1. Assess the woman's knowledge of pushing techniques and expectations around the second stage of labor (Brown & Lumley, 1994: Evidence Rating: III).

2. Assess fetal presentation, position and station prior to initiation of pushing (Roberts & Woolley, 1996: Evidence Rating: III).
3. Assess the initiation of Ferguson's reflex and the woman's readiness to begin pushing (Roberts & Woolley, 1996: Evidence Rating: III).

Intervention

1. Discuss and reinforce expectations and information about the second stage of labor, i.e. duration, sensations, pain and appropriate pushing techniques, as this stage begins (McKay et al., 1990: Evidence Rating: QI).
2. Involve the woman in the decision to start pushing (Brown & Lumley, 1994: Evidence Rating: III).
3. Support and facilitate delayed pushing until the active phase (phase II) of the second stage of labor (initiation of Ferguson's reflex) unless contraindicated by maternal or fetal condition. Delayed pushing may also be appropriate for women with epidural anesthesia/analgesia who do not feel the urge to push (Vause et al., 1998; Mayberry, Hammer et al., 1999: Evidence Rating: I) (Mayberry, Gennaro et al., 1999: Evidence Rating: III) (Aderhold & Roberts, 1991: Evidence Rating: QI).
4. Encourage women to push spontaneously as they feel the urge (Sampselle & Hines, 1999: Evidence Rating: III).
5. Women should be encouraged to push for 4 to 6 seconds with a slight exhale for approximately five to six pushes per contraction or as tolerated by the woman and fetus. Traditional breath holding for 10 seconds should be discouraged (Thomson, 1995: Evidence Rating: I) (Roberts & Woolley, 1996: Evidence Rating: III).

Expected Outcomes

1. Women will be supported in a physiological approach to the second stage of labor in which pushing may be delayed until the active phase (phase II) of the second stage or the urge to push is felt (Vause et al., 1998: Evidence Rating: I) (Caldyero-Barcia, et al., 1981: Evidence Grading: II-3).
2. Women will be encouraged to use exhalatory open glottis pushing versus forced pushing or Valsalva maneuver and discouraged from using prolonged closed glottis pushing (Mayberry, Hammer et al., 1999: Evidence Rating: I) (Parnell et al., 1993: Evidence Rating: II) (Sampselle & Hines, 1999: Evidence Rating: III).

Evaluation of Physiologic Processes

Assessment

1. Assess the woman's progress through the second stage of labor, including effectiveness of pushing efforts and descent of the presenting part (Roberts & Woolley, 1996: Evidence Rating: III) (Bergstrom et al., 1992: Evidence Rating: QI).

Intervention

Phase I

1. Encourage the woman to rest and follow her own urges, including not pushing through some contractions, if indicated (Vause et al., 1998; Parnell et al., 1993: Evidence Rating: I) (Mayberry, Gennaro et al., 1999; Gagnon & Waghorn, 1996: Evidence Rating: III) (Aderhold & Roberts, 1991; Bergstrom et al., 1997: Evidence Rating: QI).

Phases II and III

1. Facilitate descent, increase maternal comfort and minimize trauma by the following methods:
    a. Support and facilitate the woman's spontaneous pushing efforts (Liu, 1989; Parnell et al., 1993; Thomson, 1993: Evidence Rating: I) (Sampselle & Hines, 1999: Evidence Rating: III).
    b. Evaluate the effectiveness of upright or other positions (standing, kneeling or squatting) on fetal descent and maternal-fetal condition (de Jong, 1997; Bomfim-Hyppolito, 1998: Evidence Rating: I) (Gardosi et al., 1989: Evidence Rating: II-2) (Liu, 1988: Evidence Rating: II-3) (Fenwick & Simkin, 1987: Evidence Grading: III).
    c. Evaluate the effectiveness of maternal position changes on fetal descent and maternal comfort. (Aderhold & Roberts, 1991: Evidence Rating: QI)

Rapid Fetal Descent

1. Help the woman maintain a lateral position whenever possible (Albers et al., 1996: Evidence Rating: II-2).
2. Help the woman avoid sitting or squatting positions (Waldenstrom & Gottvall, 1991: Evidence Rating: I) (Albers et al., 1996; Golay et al., 1993: Evidence Rating: II-2) (Gareberg et al., 1994: Evidence Rating: II-3).

Delayed Fetal Descent

1. Acknowledge the woman's progress through the second stage of labor and support her behavior (Mackey, 1998: Evidence Rating: QI).
2. Provide feedback to the woman aimed at keeping the perineum relaxed and directing bearing down toward the perineum (Roberts & Woolley, 1996: Evidence Rating: III) (Bergstrom et al., 1997: Evidence Rating: QI).
3. Continue to support spontaneous pushing efforts (Roberts & Woolley, 1996: Evidence Rating: III).
4. Evaluate fetal position. If occiput posterior, change maternal position to facilitate rotation. Position changes may include lying on one's side or resting on hands and knees with a side-to-side pelvic rock (Roberts & Woolley, 1996: Evidence Rating: III).
5. Continue or initiate upright positioning (sitting, standing, kneeling or squatting). Provide support such as a squatting bar or other aids (Liu, 1989; Gardosi et al., 1989: Evidence Rating: I) (Gareberg et al., 1994: Evidence Rating: II-3) (Fenwick & Simkin, 1987: Evidence Rating: III) (Aderhold & Roberts, 1991: Evidence Rating: QI).
6. When possible, discourage semirecumbent or lithotomy position (Allahbadia & Vaidya, 1993: Evidence Rating: I) (Golay et al., 1993: Evidence Rating: II-2).
7. Help the woman maintain an empty bladder by encouraging her to void or by intermittent catheterizations if a full bladder is palpated and the woman is

unable to void (Cunningham et al., 1997; Oxorn & Foote, 1986: Evidence Rating: III).

Additional Considerations

1. Decisions to use perineal massage with or without lubricants should be based on individual patient condition, the practitioner's judgment and the patient's response to the procedure (Albers et al., 1996: Evidence Rating: II-2).
2. The use of fundal pressure to expedite a routine, uncomplicated, spontaneous vaginal birth should be discouraged (Zetterstrom et al., 1999: Evidence Rating: II-3) (Cosner, 1996; Kline-Kaye & Miller-Slade, 1990: Evidence Rating: III).

Refer to the original guideline document for detailed referenced rationales for each clinical practice recommendation.

Quality of Evidence

I: Evidence obtained from at least one properly designed randomized controlled trial.

II-1: Evidence obtained from well-designed controlled trials without randomization.

II-2: Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group.

II-3: Evidence from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of the introduction of penicillin treatment in the 1940s) could also be regarded as this type of evidence.

III: Opinions of respected authorities, based on clinical experience, descriptive studies or reports of expert committees.

Quality of Evidence Rating for Qualitative Studies

The quality of evidence rating is based on the total scores for each of five categories:

1. descriptive vividness
2. methodological congruence
3. analytical preciseness
4. theoretical connectedness
5. heuristic relevance

QI: Total score of 22.5-30: 75-100% of total criteria met

QII: Total score of 15-22.4: 50-74% of total criteria met

QIII: Total score of 15 or less: 50% or less of total criteria met

The categories are described in the Criteria for Quality Rating in Appendix C of the original guideline document.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

References open in a new window

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Guideline implementation can help perinatal registered nurses, certified nurse midwives, and Canadian midwives manage the second stage of labor more effectively and thus optimize perinatal outcomes, especially patient satisfaction with the labor and birth experience.
- Supportive nursing care may reduce the use of medications, the incidence of operative births and the side effects associated with both.
- Nursing presence and support also may contribute to perceptions of childbirth as a positive experience, aide in promoting attachment and family adaptation and contribute to cost-effectiveness in health care delivery.

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

The guideline was developed for the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN) as a resource for nursing practice. The guideline does not define a standard of care, nor is it intended to dictate an exclusive course of management. It presents general methods and techniques of practice that are currently acceptable, based on current research and used by recognized authorities. Proper care of individual patients may depend on many individual factors as well as professional judgment. The information presented is not designed to define standards of practice for employment, licensure, discipline,

legal or other purposes. Variations and innovations that are consistent with law, and that demonstrably improve the quality of patient care should be encouraged.

Recognizing the Needs of Special Groups

The guideline can be used to direct care during the second stage of labor for childbearing women of all ages and ethnic or religious backgrounds and may be used in some special circumstances, such as when a woman has a disability or in a situation of planned, vaginal birth of multiples. It should be stressed, however, that nurses must identify, acknowledge, and respond to the special needs of each woman. The guideline provides the nurse with suggestions for supportive care and assessment based on sound research.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). Nursing management of the second stage of labor. Evidence-based clinical practice guideline. Washington (DC): Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN); 2000 Jan. 29 p. [55 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2000 Jan

GUIDELINE DEVELOPER(S)

Association of Women's Health, Obstetric, and Neonatal Nurses - Professional Association

SOURCE(S) OF FUNDING

Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN)

GUIDELINE COMMITTEE

Evidence-based Clinical Practice Guideline Development Team

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Evidence-based Clinical Practice Guideline Development Team: Sandra K. Cesario, RNC, PhD, Team Leader; Susan Longacre, RNC, MS; Karen H. Morin, DSN, RN; Michelle L. Murray, PhD, RNC; Jacquelyn Reid, WHNP, CNM, EdD; Karen Trapani, RNC, BSN; Susan Walsh, RN, MSc.

Reviewers: Jennifer W. Burton, RNC, MSN, PNNP; Marie Cueman, RN, MSN; Rachel Hammer, MSN, RNC; Laura B. Strange, RN, MS.

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

An update is not in progress at this time.

GUIDELINE AVAILABILITY

Electronic copies: Not available at this time.

Print copies: Available by contacting the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), 2000 L Street, N.W. Suite 740, Washington, D.C. 20036; Phone: (800) 354-2268; Web site: www.awhonn.org.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Evidence-based clinical practice guideline. Nursing management of the second stage of labor: Monograph. Washington (DC): Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), 2000 Jan. 27 p.
- Nursing management of the second stage of labor. Quick care guide: Washington (DC): Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), 2000 Jan. 2 p.

Electronic copies: Not available at this time.

Print copies: Available by contacting the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), 2000 L Street, N.W. Suite 740, Washington, D.C. 20036; Phone: (800) 354-2268; Web site: www.awhonn.org.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on April 9, 2002. The information was verified by the guideline developer on June 7, 2002.

COPYRIGHT STATEMENT

Date Modified: 11/8/2004